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Family networks and the role of men in maternal health care among Mexican indigenous women

Redes familiares y el lugar de los varones en el cuidado de la salud materna entre mujeres indígenas mexicanas

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ABSTRACT This article reflects on maternal mortality among indigenous women in Mexico and the changes that have occurred in care practices during pregnancy and childbirth. Through ethnographic qualitative research in the state of Guerrero between 2008 and 2012, which included over a year of fieldwork as well as in-depth interviews and surveys with indigenous women, the article analyzes the increasing medicalization of reproduction, the role of family networks in gestation, delivery and postpartum care, and the participation of men during childbirth, in dialogue with other anthropological research on maternal health in Mexico. Medical anthropology allows us to understand the medicalization of reproduction in indigenous contexts and identify the tension that characterizes family care networks, which both operate as protectors and mobilizers in seeking care and reproduce power relations marked by gender and generational conditions.
KEY WORDS Medical Anthropology; Indigenous Population; Maternal Mortality; Community Networks; Mexico.

RESUMEN Este artículo aborda la mortalidad materna entre mujeres indígenas en México, y las transformaciones en las prácticas de atención durante el embarazo y parto. A través de una investigación cualitativa etnográfica, llevada a cabo en el estado de Guerrero, entre 2008 y 2012, cuyo trabajo de campo incluyó entrevistas en profundidad y encuestas a mujeres indígenas, se analiza la medicalización creciente de la reproducción, el papel que juegan las redes familiares en el cuidado durante la gestación, parto y postparto, y la participación de los varones durante el parto, entrando en diálogo con otras investigaciones antropológicas sobre salud materna en México. La antropología médica permite comprender la medicalización creciente de la reproducción en contextos indígenas e identificar la tensión que caracteriza a las redes de cuidado familiar las que, al mismo tiempo que operan como protectoras y movilizadoras de búsqueda de atención, reproducen relaciones de poder marcadas por condiciones de género y generacionales.
PALABRAS CLAVES Antropología Médica; Población Indígena; Mortalidad Materna; Redes Comunitarias; México.

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INTRODUCTION

Maternal mortality is a public health problem and marker of social inequality that impacts women's health in Latin America and the Caribbean. Maternal death is defined as the death of a woman while pregnant, during childbirth, or within 42 days after the termination of pregnancy, from any cause associated with or aggravated by pregnancy or its management, but not from accidental or incidental causes.[1] The *World* Health Organization (WHO) acknowledges that thousands of women in the Americas die each year,[2] principally due to hemorrhages, hypertension, direct causes, and preexisting factors. According to the Pan American Health Organization (PAHO), one in five maternal deaths in the Americas is caused by hemorrhaging during or after childbirth,[3] and in 2015 launched an initiative called "Zero Maternal Deaths by Hemorrhage."

Cases of maternal death have differentiated characteristics in terms of socio-cultural context, economic and geographic conditions, available service infrastructure, and the particularities of healthcare systems, among others. In this sense, it forms part of the field of reproduction, health, and gender – topics central to medical anthropology and to the analysis of health-disease-care-prevention processes specific to this subdiscipline. Reproduction is a socio-cultural process that is not limited to its psychological or biological aspects, but that also intersects with multiple ways of understanding maternity-paternity, health, and health care, within cultural and gender orders. Additionally, it encompasses many areas of daily life, including processes prior to pregnancy such as courtship, partner selection, sexuality, and cohabitation and union rituals. It also includes the stages of the biological reproductive process (pregnancy, delivery, and the postpartum period), productive work following delivery, early childrearing, and the socialization of the child within their group's sociocultural configuration.[4,5]

Given that it is mediated by symbolic and gender orders specific to each social group, maternal mortality presents different manifestations. That is to say, both culture and the material and structural conditions in which culture takes place construct a normativity regarding reproduction as well as representations and practices surrounding prevention, care, or the recovery of health during pregnancy, delivery, and the postpartum period. Social groups do not only define when and in what manner individuals should reproduce, but also who should take on a central role in participating, deciding, and intervening in this process, and who should do so only peripherally. This takes place alongside permanent transactions with actors who regulate reproduction – in particular the State, through its population and healthcare policies.

Reproductive processes among indigenous groups and low-income urban communities are generally characterized by the central role given to family networks – especially partners, mothers-in-law, parents, and other close family members – as well the broader community. With processes of increasing medicalization, the State takes on a more prominent role in the realm of biological reproduction and care practices associated with pregnancy and childbirth, and in doing so buttresses the participation of other actors: medical personnel, nursing and other healthcare professionals, social organizations and networks, among others. This prominence of State actors tends to disappear during the postpartum period, however, and care practices fall into the hands of family and community networks. Although regulations exist which stipulate that women be monitored for a period of 42 days after childbirth, healthcare professionals focus monitoring efforts on pregnancy and delivery, whether because the probability of death is considered to have largely passed after delivery, because of a lack of personnel, or because interventions are focused on the newborn rather than the woman.

Diverse studies in the field of medical anthropology have looked at the characteristics of maternal death and reproductive processes in indigenous regions. In recent decades, the ethnographic literature on the

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topic in Mexico has shown the complexities of this phenomenon in states such as Chiapas, Tlaxcala, Oaxaca, Yucatan, and in contexts of indigenous migrant populations in Mexico City.[6,7,8,9,10,11] Various authors have provided evidence of the transformations in care provided during pregnancy and childbirth associated with the greater presence of institutions and health programs or with processes of urbanization and migration. Furthermore, they have shown how gender inequalities are another element impacting maternal mortality or the search for care, as well as the role of social networks (particularly family ties) in self-care practices.

METHODOLOGICAL ASPECTS

This article is based on my doctoral dissertation, titled "Between community normativity and health institutions: Reproductive processes and maternal health among indigenous women in the Costa Chica region of Guerrero."[12] In my research I analyzed care practices during pregnancy, childbirth, and the postpartum period through the lens of the limitations and possibilities surrounding reproduction as defined by institutional and community normativities.

Additionally, the role of social networks is considered – in particular family networks, especially the men that form part of them – with respect to care practices during childbirth. The study focuses on a multiethnic region located in Southeast Mexico: the Costa Chica region of the state of Guerrero. In the past decade, the state of Guerrero registered one of the country's highest maternal death rates.

Fieldwork was carried out during 2008-2009 (and finalized in 2012) with two indigenous communities of the Costa Chica region: *Nancue Ñomndaa* (Amuzgo) and *Na Saavi* (Mixtec). In addition, a survey was designed and implemented with 100 women aged 15 to 49. The purpose of this survey was to gather information on aspects of the women's sexual and reproductive history, on each one of their pregnancies and deliveries, mortality, morbidity, the type of healer they consulted in each instance, their social security eligibility and social program coverage, basic demographic data and other information. Fifty women from each community were selected, such that the proportion of women from each age group was representative of the community's age structure as a whole. Given that the objectives of the study were concerned with accessing information related to the care experience of women belonging to different age groups, the selection criteria were that the women had experienced at least one pregnancy during their lifetime and that they agreed to participate in the study, assuring that the required number of women in each age group would be surveyed. This allowed for the construction of reproductive trajectories for individuals as well as age groups. A more detailed explanation of the methodology and findings by age group can be found in a previous publication, in which these aspects are more fully described.[13]

In-depth interviews were conducted with women, men, community health workers, and medical personnel, and participant observation was carried out at community hospitals (primary care facilities) in the municipality of San Luis Acatlán and at the Regional Hospital of Ometepec (secondary care facilities), which provides service to 15 of the region's municipalities. This research also included a review of State programs and public policy, official health statistics, and budgetary allocations, though this information is not included in the present article.

Verbal informed consent was requested of all study participants. The doctoral research protocol was approved in 2008 by the Anthropological Sciences Graduate Committee at the Universidad Autónoma Metropolitana prior to initiating fieldwork. The results of this study were presented at subsequent graduate colloquia and approved by the dissertation committee in December of 2013. The names in this text have been changed in order to maintain confidentiality.

Among the wide range of studies on maternal health within the field of critical medical anthropology, a number of different

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approaches can be found: ethnographic studies; quantitative studies based on official health databases; socio-cultural epidemiology studies; analyses of institutions, public policy, or governmental action; and studies that look at the transformations in these practices for different generations or families, combining synchronic and diachronic analyses.

This article dialogues with major studies on maternal health in indigenous zones of Mexico, reflecting on the common threads of their findings. Mari Carmen Elu's groundbreaking study of a rural area in Tlaxcala was conducted at the beginning of the 1990s – a time when the Safe Motherhood Initiative was gaining traction internationally – and paved the way for qualitative approaches to studying the lives of deceased women and the cultural framework within which their stories and practices were inserted.[9] Comprehending the socio-cultural causes of maternal death in rural areas from an anthropological viewpoint was fundamental in order to rethink actions aimed at its prevention. This approach has been widely utilized by medical anthropologists who document the multiple aspects, tensions, and transformations of the representations and practices of Mexico's diverse indigenous groups with regard to pregnancy, childbirth, and the postpartum period.

This article begins by analyzing maternal mortality and the medicalization of reproduction in indigenous regions of Mexico; then, the results of my research in the Costa Chica region on care practices during gestation and childbirth are presented; finally, the role of family networks are analyzed, in particular the role of men in these practices.

MATERNAL MORTALITY AND THE MEDICALIZATION OF REPRODUCTION

According to the WHO, in 2013 the Maternal Mortality Ratio (MMR) for the Americas was 68 maternal deaths per 100,000 live births, which is in general lower than the global average (220 maternal deaths per 100,000 live births that year). It can also be observed that from 1990 to 2013, there was a 40% reduction in maternal mortality in the Americas. Despite these trends, according to the basic health indicators in the Americas 2015 report, in the year in question 5593 women died from causes related to pregnancy and childbirth.[3] Existing data on maternal death in Latin America face differences among sources that make it difficult to establish the number of maternal deaths with certainty. A report published by the WHO, UNICEF, UNFPA, and the World Bank in 2014 cites a figure of 9300 women.[14] WHO data indicate that in 2015 there were 5593 cases of maternal death;[15] however, this does not include information on countries that had not reported data or that had only reported preliminary data. The WHO reports estimates of maternal mortality applying an adjustment factor, which would allow us to consider a figure of 7300 maternal deaths for Latin America and the Caribbean in 2013.

Inequalities in the distribution of maternal mortality is a serious problem; the countries with the lowest maternal mortality ratios in the region are Canada, with 11 per 100,000 live births, Uruguay with 14, Chile with 22, and the United States with 28. The countries with the highest ratios are Haiti with 380, Guyana with 250, Bolivia with 200, Guatemala with 140, and Suriname with 130.[2] Countries such as Peru, Brazil, El Salvador, Barbados, and Ecuador have seen significant declines in maternal mortality rates from 1990 to 2013, and now form part of the group of countries with low maternal mortality (that is, less than 100 maternal deaths per 100,000 live births). Other countries such as Mexico, Belize, Chile, and Santa Lucia were already included in this group, but continued to reduce their maternal mortality rates to the tune of 40% during the same period.

While these data provide a general picture of the situation, they conceal inequalities between regions and between social groups within each country. In Mexico, the MMR in 2014 was 39.8 per 100,000 live births, but some states surpassed this level: Durango

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with 71.2, Chiapas with 68.1, Hidalgo with 65.5, Guerrero with 58.7, and Chihuahua with 56.5.[16] Several of these states also have high levels of poverty and lower values in human development indicators. The case of Durango is peculiar: despite being a northern state, as in the case of Chihuahua, it has traditionally had higher levels of maternal mortality with respect to the national average due to its geographically dispersed population and accessibility issues in the municipalities of the Sierra region. Although it has a relatively low number of deaths, its MMR is high due to a lower population density. In 2014, Durango had 25 deaths due to obstetric causes and a MMR of 71.2, the highest level in its history and the first year that its MMR was higher than the southeastern states of Chiapas, Guerrero, Oaxaca, or Veracruz.[16]

The literature on the topic also reveals that beyond issues of poverty and geographic inaccessibility, certain population groups face more adverse conditions associated with processes of racialization and inequalities derived from their ethnic identity. Indigenous populations are one of the most vulnerable groups in this regard, and in these regions the MMR is considerably higher. In Latin America, countries with the largest indigenous population – Guatemala, Bolivia, Peru, or Ecuador, for example – have the highest maternal mortality ratios, and in indigenous zones these are even more pronounced.[17]

Graciela Freyermuth has found that in the Chiapas highlands, Tzotzil women in the municipality of Chenalhó are three times as likely to die as Mexican women in general and two times more likely than women in the state of Chiapas as a whole.[6] These trends persisted in 2013 when comparing indigenous and non-indigenous women.[18] The same can be said for populations of African descent in countries such as Haiti or Brazil, where maternal mortality is more prevalent among black women, and racialization processes in the care provided by health personnel constitute forms of institutional bias. Cecilia MacCallum has shown this in her study on the care provided to black adolescent women at the maternity ward of a public hospital in Bahia.[19]

The association between poverty and ethnicity in relation to maternal mortality is articulated with strategies aimed at expanding biomedicine and care provision during childbirth by healthcare personnel. International goals that have been set and adopted by Ministries of Health seek to achieve 100% of deliveries attended to in institutional settings. Regulations regarding indigenous populations vary from declarations in favor of respecting their cultural characteristics, worldviews, and health practices – and even include the implementation of strategies of intercultural adaptation – but in practice prioritize the expansion of the biomedical system. This expansion is not only not rejected, but actively demanded by indigenous populations, who seek biomedical care and products. However, according to Menéndez, what is rejected is the predominant type of doctor-patient relationship, mistreatment on the part of medical personnel, and institutional racism.[20]

In indigenous zones of Mexico, despite recent budget cuts, there is an ever-increasing State presence in reproductive processes and issues related to women's bodies in the form of State programs, actions, recommendations, and public policies. In addition to a focus on pregnancy, childbirth, and the postpartum period, a series of strategies and discourses permanently appear related to the control of birth rates, family planning aimed at smaller family sizes, a reduction in the number of children per family, and the greater use of long-term birth control methods. These discourses emanate from institutions, government officials, international organizations or foundations, and civil society organizations, and constitute a range of initiatives aimed at modifying the reproductive behaviors of women.

Their effects are observed in the transformations in knowledge held by indigenous women and men, and are expressed even more resoundingly among younger generations. In this way, natural processes of the life cycle such as pregnancy and childbirth are medicalized and turned into an object of specialized interventions on the part of the professional medical field.[21] State regulation

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regarding reproduction is articulated with medical knowledge, thereby promoting medicalization processes.

At present, nine out of ten registered births in Mexico take place in healthcare institutions and over 94% of women attend prenatal consultations provided by healthcare personnel. The institutionalization of childbirth and the predominance of biomedical care is evident in the fact that in 2015, of the country's 2,080,543 births, only 23,650 (1.13%) were delivered by traditional midwives. In the same year in the state of Guerrero, 1520 (2.46%) of the 61,970 registered births were delivered by midwives.[20] In states with large indigenous populations such as Chiapas, Veracruz, Puebla, Guerrero, and Oaxaca, the percentage of births attended to by midwives is higher than the national average. However, the analysis of *Na Saavi* (Mixtec) y *Nancue Ñomndaa* (Amuzgo) women in the Costa Chica region confirms the expansion of the biomedical model, especially among younger women in the early stages of their reproductive age.[5]

In Guerrero, research has shown the predominance of hospital delivery among younger women, as eight out of ten women between the ages of 15 and 24 surveyed reported having their most recent child in a healthcare institution, with only 20% reporting home delivery. In contrast, for women over the age of 25, six of every ten chose to have a home delivery performed by a midwife, alone or with their partner. Both women aged 25-34 and women 35 and over tend to favor home delivery and their trajectories show a greater emphasis on traditional therapies or self-care. Younger women have higher percentages of hospital delivery, which can be linked the context in which their reproductive lives began – the expansion of the biomedical model and the institutionalization of care, which become naturalized. The most common explanation for this preference provided by young women is the sense of security that hospital care provides them, along with the recommendation of healthcare personnel during prenatal consultations that they report to a healthcare institution upon going into labor. This sense of greater security is also held by young men, which reinforces women's motivations to seek biomedical care. Lastly, it is worth noting that there has been a significant increase in the number of women who delivered via cesarean section, and that this is particularly evident among primigravidae and secundigravidae. The majority of these pregnancies have been classified as high-risk and therefore the women have been referred to hospitals. These phenomena can be used in order to comprehend the expansion of biomedicine among young women.

These findings coincide with anthropological research on the topic, such as Freyermuth's study of the Chiapas highlands region, which has provided evidence of medicalization in indigenous contexts. Although women in this region still express a preference for seeking care from specialized indigenous health agents – such as *j´iloles* and *j´loktor ja´jchi´iltic* – they also seek care from medical personnel, regardless of whether they possess an indigenous or Western worldview:

> The medicalization of childbirth – represented above all by the appropriation of the use of patented drugs such as oxytocin – is more common among younger women or the newly initiated generation. Older women or those in the stage of predominance reported not using drugs and not seeking medical care or the care of a midwife for their deliveries.[6]

Paola Sesia and Matías Sachsse documented the dismantling of primary health care in rural communities in Oaxaca, along with a very high number of referrals to secondary care facilities. This has the effect of overwhelming obstetric services at secondary care facilities, diminishing their capacities for care provision in cases of obstetric emergencies and negatively impacting the quality of care.[10]

In the case of Yucatan, Judith Ortega has demonstrated the expansion of biomedicine among the Mayan population and the corresponding decline of traditional health services, particularly traditional midwives.[7]

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Younger generations show clear preference for biomedical resources. Ortega discusses the role of men during pregnancy and childbirth, demonstrating that they have tended to become less participative during labor and in activities such as *sobada* [traditional therapeutic massages] as that there has been an increase in deliveries taking place in institutions of the Mexican Social Security Institute (IMSS), along with the increased influence of the biomedical ideology.[7]

Zuanilda Mendoza analyzes the changes in reproductive processes between two generations of native Triqui families who were migrants to Mexico City from Oaxaca, and describes the practices enacted by men and women during pregnancy, delivery, and the postpartum period.[23] She demonstrates generational differences regarding care provided during pregnancy and the type of delivery, given that in the stories she reviews, the oldest woman's nine deliveries took place in her home accompanied only by her husband, while the youngest woman had a hospital delivery.[23] Differences were also observed in the handling of the placentas; in the case of the older couple, all were invariably buried in order to prevent sickness in the newborns, while in the case of the younger couple the placenta was disposed of by hospital staff. In these stories, the postpartum period was a decisive moment in which care returned to the realm of the family, and included monitoring by mothers, mothers- and sisters-in-law, husbands, family members, and midwives:

> Childbirth is the period in which allopathic medical practice has gained ground, perhaps due to the fact that it is the most feared moment in terms of risk of death for mother and child. Second-generation women and men have representations of healthcare professionals' technical capacities as an element that contributes to greater certainty in the outcome of delivery, thereby assuring survival. The impersonal, institutional care provided outside of the home and without the company of the family is not called into question: they base their decision on the professional's technical capacity and the resources they have access to in order to ensure effectiveness.[23]

In Guerrero, the same logic operates that places more trust in biomedical care in the event of complications during childbirth. Nevertheless, complaints are still prevalent among women with respect to the care received, the lack of personnel that speak their language, and the disrespect toward their traditional forms of care, their protection rituals, and their forms of delivery. Similar to Freyermuth's findings in Chiapas,[6] men's experience brought about changes in practices of access to healthcare services and the medicalization of the reproductive process, as more educated men or those closer to urban centers encouraged their partners to seek care in healthcare institutions.

On multiple occasions during my fieldwork I spoke with young men who were waiting outside the region's hospitals while their wives or partners gave birth inside, given that the presence of family members is not permitted once the woman has been admitted. In all cases they were young men aged 25 or under who had decided, together with their partner, to seek care in a hospital. In some cases, they were accompanied by their fathers or fathers-in-law, who took part in this decision "*so that nothing would go wrong*" or so as to "*not have problems with the girl's parents if something happens to her.*" In one instance, as I accompanied a young couple who headed to the *Casa de la Mujer Indígena* – an institution where women are attended to by traditional midwives – after labor had started, I asked them where they wanted to deliver, and it was the young man who responded:

> *…we'll be here with the midwives while the labor pains get more intense, but as soon as it's time to deliver we're going to the hospital because it's safer.*

It is interesting to note that after delivery, many of these young men carry out placenta burying rituals alongside their parents or in-laws, given that this is a primarily male activity.

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The reproduction of life in the Costa Chica region of Guerrero

The most recent census, in 2010, reported that the Costa Chica region of Guerrero – a 180-kilometer zone along the Pacific coast, lined with mountains and valleys – was inhabited by nearly 500,000 people.[24] Sun-kissed men and women pass through its hilly landscape, green in winter and terracotta-colored in summer. *Na Saavi* (Mixtecs), *Me´phaa* (Tlapanecs), *Nancue Ñomndaa* (Amuzgos), Afro-descendants, and mestizos may all be found in this vast territory composed of 15 municipalities: Ayutla de los Libres, Azoyú, Copala, Cuajinicuilapa, Cuautepec, Florecio Villareal, Igualapa, Juchitán, Marquelia, Ometepec, San Luis Acatlán, Tecoanapa, Tlacoachistlahuaca, and Xochistlahuaca.[25]

The indigenous population is concentrated in the municipalities of mountainous areas, whereas populations of African descent are mainly located in coastal areas. The principal economic activities of the region include subsistence agriculture, commerce, livestock production, fishing, and craft production.[26] In mountain communities, *Na Saavi* women can be seen with their vibrantly colored skirts, adorned with geometric designs, and their *hupiles* – traditional handmade blouses that they embroider with all types of animals, such as birds, turkeys, or squirrels.

Characterized by their strong arms, both *Na Saavi* y *Ñomndaa* men and women begin their productive lives at a very early age, either as farm workers or domestic workers, although their income is often insufficient to cover their basic needs. This partially explains the increase in out-migration in the region, not only among the *Na Saavi* – who have a long history as temporary migrants to the farms of Northern Mexico or the United States – but also among other indigenous groups, who migrate to more nearby places (such as other cities in the state of Guerrero or to the country's capital) in order to take on employment as construction or domestic workers.

The union of couples occurs at an early age, given that community norms expect women to find a partner at age 15 or 16. Birth-spacing intervals are on average two years, meaning that 25-year-old women will generally have four to five children, and many choose – or are pressured by the healthcare sector – to use permanent contraceptive methods. Other women may continue to have children until after age 30, which means that a span of almost fifteen years will be dedicated to reproductive labor: pregnancy, childbirth, postpartum care, nursing, early childrearing, and the socialization of children by women.

Biomedical practices have been increasingly incorporated into pregnancy, including prenatal consultations, laboratory exams, and ultrasounds. These services make up the package of basic care offered to pregnant women, including those uninsured women who are only covered by the System of Social Protection in Health, known as *Seguro Popular*. This program – created in 2004 – counts among its affiliates the population attended in dependencies of the Health Secretariat in all federal administrative divisions.

The women of the region and of other indigenous zones combine the traditional care practices of midwives – such as check-ups, *sobadas*, and *manteadas* [a practice in which the pregnant woman is gently rocked on a blanket or shawl] – with this package of basic interventions. They accept the latter due to institutional pressure (specifically conditional cash transfer programs) and because they consider that it will provide greater security in the monitoring of their pregnancy. This relationship with new diagnostic technologies has become so prevalent that many midwives require that women undergo exams and ultrasounds before accepting to attend to them, such that they are able to confirm that the pregnancy is progressing well. This coexists with institutional pressure placed on midwives in order to prevent them from attending to deliveries.

As Mendoza discussed in her work with the Triqui community, the hegemony of the biomedical system is particularly salient with regards to delivery, given that there is a strong tendency toward institutionalization and the control of procedures, spaces, schedules, and personnel involved, which are all defined by

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healthcare institutions.[23] The elimination of fees covering childbirth in 2009, combined with maternal health programs and conditional cash transfer schemes, have all contributed to this increase.

Receiving care at a health center implies that the women and those who accompany them must leave the community, and in the case of complex procedures must travel to the municipal seat or to a secondary care facility, which can double travel times. A component that marks the experience of many indigenous women of the Costa Chica region is the fear of the unknown, of the consequences of venturing outside of the community, of travelling to a city that they are not familiar with, and of dealing with the institutional logics of hospitals. Part of these fears stem from the possibility that something could happen during childbirth or while in the hospital, leaving the woman on her own and without a support system to look out for her.

DISCUSSION: THE ROLE OF FAMILY NETWORKS IN HEALTH CARE DURING CHILDBIRTH

Eduardo Menéndez has stressed the importance of a relational perspective in descriptions and analyses, and a consideration of the different actors involved in health-disease-care processes.[27] He shows that there are different types of relationships and contemporary rituals in a variety of settings – the workplace, health care, religion, family – contradicting perspectives that contend that there has been an erosion or disappearance of social relationships and consider individuals to be isolated beings.[27]

I concur with this author, in that "all subjects are constituted within social relations, and their trajectories will be shaped through relations of collaboration, mutual help, competition, or struggle."[13] Insertion in social relations and the existence of contemporary rituals surrounding reproduction are not exclusive to rural societies, indigenous groups, or low-income groups; this is expressed differently in each cultural context and it can be clearly seen how these networks and relations become activated in relation to specific events regarding health care. That being said, I echo Menéndez's recommendation to not consider these relations as naturally positive, and therefore to take a closer look at the tensions that characterize them – that they do have a role in protecting health, but at the same time they reproduce power relations.[13]

Even when the medicalization of pregnancy, childbirth, and contraception are focused on women as subjects to be controlled, watched, or taken care of, this process of individualizing (or even isolating) women once they are admitted to a hospital during labor does not eliminate the central role of non-professional networks and their forms of "lay care," to use Haro's terminology.[26] For women this could indeed represent the difference between life and death.

In cases of emergencies or complications, the decision of where to turn is rarely made solely by the woman in question, but rather members of her close social circle participate in the decision; in particular, mothers- or fathers-in-law, spouses or partners, sisters-in-law, and mothers and fathers, but also neighbors, more distant family members, local healthcare agents, or community authorities. These networks activate in key moments and may operate as a factor in the protection of the woman's health, but also set into motion power relations characterized by gender or generational inequalities, which can contribute to putting the woman's life at risk or leading to her death in cases when it is decided not to seek care.[6,28]

Menéndez is clear in his questioning of whether social relations are "good in and of themselves," or should be assigned a protective or beneficial role with respect to health-disease-care processes.[13] Anthropological literature on maternal health in the indigenous population of Mexico has extensively documented that situations of violence against women – including those that occur during childbirth – are associated with microsocial relationships in the context of the

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family, marked by relations of subordination within and between genders.

While mothers, mothers-in-law, and sisters-in-law can encourage pregnant women to seek care and involve men, they are also subjects that exercise power over younger women and may make the decision to not seek help in the event of an emergency, especially if the pregnant woman is orphaned or has no support network of her own. In some cases, horizontal networks – such as those constructed with community health workers – can take on a decisive role, especially in the event of complications; these networks can be fundamental in the mediation between the indigenous world and the biomedical world. Findings such as these are possible through analyses that integrate gender as a variable of analysis.

Therefore, social relations are not considered intrinsically positive or protective of health; they must be analyzed in context in order to capture the different nuances depending on the disease, persons involved, and existing power relations. During a young Amuzga woman's first delivery, when she was 14 years old, her in-laws decided not to take her in for hospital care in the midst of a prolonged period of midwife-assisted labor:

> *When I was living with them I had my first child, they never supported me, they would just tell me that a woman has to suffer to have her children. Yes, because as my mother-in-law would say, she's not fat, she's skinny and all of her children were born normal, she had to push and so I would have to as well, even though I ended up all bruised after delivering. I would have preferred that they take me in, but my husband did what his parents said. (Lizbeth. Ñomndaa, 26 years old, five children)*

At the same time, Ana, a 15-year-old *Na Saavi* woman, was reprimanded by her mother-in-law to go have laboratory work done at the hospital, despite the fact that she did not want to. The mother-in-law instructed her husband and son to gather the money needed to get Ana to the hospital and accompanied her the entire time. Lucia, a 23-year-old *Na Saavi* woman, had her life saved thanks to the mobilization of her husband's entire family when she nearly miscarried her second child.

Recent anthropological studies carried out by participants in the Gender, Health, and Reproduction Seminar that I coordinate with Dr. Ángeles Sánchez – all of whom are graduate students at the Universidad Autónoma Metropolitana, the Universidad Nacional Autónoma de México, and the Centro de Investigaciones y Estudios Superiores en Antropología Social – present similar experiences in urban contexts. Graciela Muñoz looks at maternity among women affected by homelessness in Mexico City, and finds evidence that social ties with families of origin are activated during pregnancy.[29] In many cases, these families that have often driven out these young women due to situations of violence and sexual abuse within the domestic unit, take on the care and socialization of the children, while the mothers return to the streets.[29]

A study carried out by Irma Romero analyzes cases of women who died from severe obstetric complications at the National Institute of Perinatology (INPER), a specialized tertiary care center, looking at what happened with the children and the families of the young women after their death.[30] Invariably it was the family of the deceased women who took on the care of the newborns that survived their mothers. Some of the men – the children's fathers – did so for a period of time, but later left the responsibility with their mothers, mothers-in-law, sisters, or sisters-in-law.[30]

This is consistent with Bianca Vargas' findings regarding rural women in the Lake Pátzcuaro basin (in Michoacán) who died of causes related to childbirth and whose children remained in the care of grandmothers or aunts.[31] In both studies it is possible to observe the role of kinship networks in seeking care and their active participation in the selection of healthcare providers, as shown by Claudia Carrera regarding urban couples that use humanized birth services in the public and private sector in Mexico City.[32]

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Men's role in care during childbirth

As Benno de Kjeizer,[33] Figueroa and Franzoni,[34] and others have pointed out, men's health-disease-care processes have remained largely invisible in studies, health policies, and programs from a gender-based perspective. Indeed, as Kjeizer argues, gender is not only a source of inequality, but also an explanatory framework to comprehend different ways of understanding health or illness, of becoming sick, of dying, and of attending to and maintaining one's own health and that of others. It also allows us to comprehend the norms that structure relations between the feminine and the masculine, as well as the diversity of social arrangements that organize the spaces occupied by men and women within a group, the relation with the body, and care-prevention practices put into motion by each person. Although these issues have an individual dimension, they are undoubtedly shaped by gender relations. The literature on reproductive health – and this study is no exception – has placed a great deal of emphasis on women's viewpoints in the analysis of their representations, behaviors, sexual and reproductive practices, access to decision making, and knowledge and use of contraceptive technologies, among others. Rojas[35] argues that much of the research on fecundity and reproduction has privileged women on different theoretical and methodological grounds, based on a questioning of assumptions already taking place in demography and in the social sciences in general. This author presents an interesting review of classic and contemporary studies of men's participation in reproduction and parenting, calling attention to recent qualitative studies that give accounts of contemporary practices, meanings, and representations regarding reproduction on the part of men.

With respect to studies concerning maternal mortality, analyses are primarily focused on women, possibly because it is women who face the risk of death. Nonetheless, a central contribution of the social sciences, particularly of anthropology, is the analysis of the diverse actors that influence the phenomenon and the central role that both men and older women have in affecting reproductive processes and decision making in terms of seeking care. Without a doubt, it is necessary to recognize and examine in greater detail the role of men in allocating different types of resources for the recovery of health in cases of obstetric emergencies, both during pregnancy as well as during delivery and postpartum.

My own research has placed focus on the experience of women, and their importance in these processes is clear. However, in my fieldwork I have also come across valuable information regarding prevention and care duties that are clearly the responsibility of men, just as these groups consider that periodically attending consultation with different types of healers, "having the strength to give birth," maintaining the balance between heat-cold, and adhering to dietary restrictions are the responsibility of women. In the case of the Costa Chica region, men take on functions at different moments during pregnancy, such as providing company, care, or supplies. Additionally, they perform protection rituals during pregnancy in order to prevent or counteract possible actions such as witchcraft or curses, accompany women during delivery (in the delivery room or outside of the hospital), bury the placenta after birth, and as was previously the case in Mixtecs, prepare the *temazcal* [a traditional sweat lodge] for the postpartum period. In other words, their duties are not limited to that of breadwinner nor are they considered to be an actor that only restricts rights and perpetrates violence.

Speaking with men between the ages of 50 and 70, it became clear that they were present during delivery and postpartum. For many, delivery took place in adverse conditions and without sufficient care resources, as they often lived on ranches outside the community. This made it so that they were the ones tasked with calling the midwife or taking over when labor commenced, supporting the woman so that she could "push," heating the water for the postpartum bath, catching the newborn, verifying that the placenta was expelled, cutting the umbilical cord, and burying the placenta after labor was

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complete, in accordance with the traditions of each community.

On the other hand, women prepared implements necessary to warm the body (teas, covers), gave birth, bathed themselves after delivery (from the waist down in order to avoid becoming cold), cleaned the newborn, and immediately began breastfeeding. Such self-care practices are described by Ernestina, a 47-year-old Amuzga woman with 14 pregnancies, who was cared for by her husband Enrique:

> *We were on our own for three deliveries, just the two of us. We let the baby fall naturally, then he would let me go, I would prop myself up in a chair and he would check to see if the baby came out with the placenta and everything. So he would look and see that the baby was starting to come and check to see if there was any liquid. And that yes, the placenta had already fallen. We were on our own like that when I gave birth to several of my daughters and to one who died. I knew it was time because I could feel the baby start to crown. That moment when the baby started crowning I couldn't walk at all, I couldn't sit or lie down. So that's how I knew, and would lay out the towels, put down a mat and lay out some old towels, and then kneel down so the baby wouldn't get dirty. While I was doing that he would make me my tea, because here it's our belief that if your body is too cold that's why the birth doesn't progress. And at the time when we were up in the hills, then what I would do is prepare my chocolate, bulbs, and packets of cumin. If I saw that the baby was not coming along quickly then I would make my cumin tea, put half a piece of chocolate, and after drinking my tea then instantly the pain would start coming on. So he already knew when I didn't even want to go make my tea and he would say, 'where do you keep the cumin?' 'Where did you put the chocolate to make your tea?' And as I got cooler and cooler I would drink it. Then meanwhile he would start getting ready, he would go get the scissors and thread to tie off the baby's belly button and the bottle of alcohol. (Ernestina, Amuzga, 47 years old, seven surviving children and 14 pregnancies)*

The use of oxytocin during childbirth, self-administered without a prescription, is not a common practice in the region as it has been documented in other areas of the country. Nonetheless, the fact that this woman used it demonstrates a transformation in knowledge surrounding childbirth and a combination of traditional and biomedical practices. The health risks derived from its improper administering are evident.

During the postpartum period, if women did not count on the help of family or neighbors, men assured that their wives' nutrition needs were met, but this role was often taken on by another woman. According to the accounts, men would go to the hills to gather the necessary leaves for the herbal bath, which meant being able to recognize the plants and their properties, knowledge that they had acquired from their wives, mothers, mothers-in-law, or from midwives, as Beto, Rogelio, and Enrique responded when asked how they learned. Once the leaves are collected, the responsibility of boiling them and helping with the bath for several days also partly falls on the men.

An interesting cultural difference between *Na Saavi* and Ñomndaa men is that male birth assistants exist among the former, something that is not observed in the Amuzgo region. In the Buenavista community and its surrounding settlements, there are around four male midwives that regularly attend to pregnant women just as their female counterparts do. The majority of them had learned from their fathers- or mothers-in-law and even through the experience of attending to their wives' deliveries.

Enrique, Ernestina's husband, is a Mixtec man who learned to attend to his wife's deliveries with the help of his mother-in-law. After his first wife died, he married Ernestina

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(a Ñomndaa woman), and has been present for six of her births. While not a male midwife, he has attended to 16 births throughout his life – all his own children with two wives – due to necessity, because of the lack of care resources.

> *I learned from my mother-in-law who was a midwife. The mother of my first wife. And she was one of the good midwives, it's just that in those times there were no doctors they could work with, but she really was a good midwife. I would watch and she explained to me what to do, and that's how I would do it, I would just jump in since I didn't know. So your mother-in-law starts telling you what to do, grab the blanket, do this or that. The first time I helped her I just jumped in, I didn't think about if I was doing it well or if I was doing it wrong. Who knows. But I helped. And that's how it went, I helped out in all of my wife's deliveries. I would go get the midwife and I would be right there with them. I'd just watch, I'd pick up the baby. I'd hold her by the waist, right here, I'd hug her close and she would hold onto my neck. When we [Ernestina and I] left and came here it was just me and the midwife. I got everything ready, she did her part, there was no doctor. I gave her the cumin tea, a piece of chocolate. She told me that the remedy was ready, give it to me and I'll take it. (Enrique, Na Saavi, 70 years old)*

In many instances, attending to delivery implied tying off the umbilical cord. According to Enrique, he learned this by trial and error, but Ernestina points to this with great pride as something that he knows how to do. In reference to the birth of their first daughter, she recounts:

> *I was only in pain for about two hours, and then she was born. He – my husband – cut the umbilical cord, but he still called for my mother. But when my mother came in it was already done, he had already cut the umbilical cord. That's why he's so good at tying off belly buttons. Because sometimes they aren't tied right and they start to bleed, but all of my babies' were done well because he ties them tightly. (Ernestina, Amuzga, 47 years old, seven surviving children and 14 pregnancies)*

Therefore, there is a significant presence of men in the role of helper during childbirth, especially for women who have had a large number of pregnancies, who have often had their children alone at home or with their spouse or partner. This presence is also noted postpartum, with respect to the herbal baths and other activities aimed at maintaining the woman's health, all of which is consistent with the findings of other studies. In the Chiapas highlands and other regions of the country, men support the women while they are standing or massage the uterus in order to aid delivery, with the women kneeling and the men sitting. In the coastal region of Guerrero, men support women with their legs as they are both a seated position, or facing the women as they kneel and the midwife delivers the newborn.

Ortega, for example, describes in great detail the representations of Mayan men regarding how certain ailments in newborns can be traced to excessive alcohol or tobacco consumption on their part.[7] Additionally, the author shows how men take on women's physical and emotional care during pregnancy, including sexual practices.

Some activities have transformed, such as the use of the *temazcal* postpartum, which has been replaced by the herbal bath. This leads to a reduction in men's participation, given that the herbal bath is prepared by the mother-in-law or by other women. Among younger women, these practices disappear and are replaced by the accompaniment of men during delivery – at home or at the hospital – and support in providing care for the woman and the newborn.

In hospital deliveries in San Luis and Ometepec it was possible to observe the participation of men in accompanying their

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partners during the process, buying medicines, authorizing procedures, picking them up upon discharge to ensure they get home safely, and interacting directly with healthcare personnel. In many cases, the hospital's medical personnel addressed them in order to explain things or to ask for the authorization to carry out obstetric or family planning procedures, and to give instructions regarding medication, discharge, or payment.

Among healthcare personnel in the Costa Chica region, there is a general perception that men are not very present in care processes during pregnancy. This is one of their primary complaints, as they consider that numerous cases of maternal death or complications stem from the scarce interest shown by men or their cultural resistance to permitting medical care. Nonetheless, this study shows that men have an active presence, despite the fact that the contexts and manners in which they participate have changed given the increased medicalization of these processes.

On a number of occasions I was able to accompany young men who were waiting outside of hospitals while their partners were in labor. Similarly, they organized transportation and pressured personnel to attend to the women in a timely manner. Although it is possible that their participation was not what healthcare personnel expected, they were indeed present, even prior to gestation. This is consistent with the findings of other studies conducted in the Yucatan region,[7] the Mazatec zone of Oaxaca,[36] Veracruz,[37] Chiapas,[6] as well as in the analysis of several court cases of maternal death.[11]

The role of men in the reproductive process is a topic that merits further research, even though the literature reviewed demonstrates that their participation takes on diverse forms. Among older people, focus was placed on care processes during childbirth and postpartum. Today, that presence takes on new forms. The family networks that protect women and guarantee their integrity, health, or search for care in this period (particularly in cases of emergency), coexists with a gender normativity that justifies the subordinate status of women and produces symbolic, emotional, and even on occasion physical violence. My intention is not to ignore these forms of physical and symbolic violence perpetrated by men that take place in the realm of reproduction, but it is also important to reveal practices that protect women's health which occur on a daily basis. This is an issue that should be further examined from an anthropological perspective that explicitly incorporates a gender analysis, one capable of revealing the tensions and power relations between genders and generations, with the express purpose of rethinking health-disease-care processes.

CONCLUSIONS

In this article I have reflected on care with relation to maternal mortality and how it provides evidence of the changes in care practices during pregnancy among younger generations of *Na Saavi* and *Nancue* Ñomndaa women and men in the Costa Chica region of Guerrero. Such changes in part respond to the expansion of biomedicine and the population's incorporation of its logic, especially among younger people.

At the same time, I have attempted to show the importance of social ties (especially kinship networks) in care practices or the search for assistance during childbirth. This was based on the assumption that social relations are not intrinsically positive; they may act as factors that protect health, but may also reproduce gender inequalities. In particular, I emphasized men's participation during childbirth and argued that despite the perceptions regarding their low levels of involvement common among healthcare personnel, in the women's experience they are indeed present. This holds both for older women, who men actively accompanied, and for younger women; even when the institutionalization of birth excludes them at times, men continue to participate and accompany in many ways that must be acknowledged.

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Lastly, I have demonstrated some of the contributions of medical anthropology to the comprehension of the social meanings associated with reproduction, as well as different manifestations of reproductive processes and maternal mortality in indigenous contexts. Since Mari Carmen Elu's pioneering study, the research on the topic has become more diverse, and includes theoretical and methodological approaches based on ethnographic work, with analyses of structural and institutional elements that contribute to the present configuration of reproduction. Medical anthropology, combined with a gender-based perspective, is a fertile field of study for rethinking health-disease-care processes with respect to reproductive health and maternity. It is also key in understanding the differential effects of gender socialization with respect to how the places occupied by men and women are structured and normed, both within their own family structures and within community and health institutions.

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